JennScents®
HOLISTIC AROMATHERAPY

CLIENT INTAKE FORM

Please take a moment to carefully read the following client disclaimer and declaration, and sign where indicated.

Health Assessment Goal:

To provide relevant information from the client to the practitioner for the purposes of discussing main health goals.

Disclaimer:

I understand the purpose of this consultation is for educational purposes only and is not intended to treat, diagnose, cure, prescribe or replace appropriate medical guidance. I have willingly requested this consultation with _____, a Holistic Phyto-Aromatherapist.

Client Declaration:

- I am committed to learning a natural health path to enhance my quality of life that includes herbal supplements, aromatherapy and other natural health disciplines.
- I desire to incorporate healthy habits into my lifestyle and way of living to create a better health environment.
- I understand that it is my personal decision to follow a supplemental program or not to follow it.
- I thoroughly understand that this analysis does not replace any additional professional counseling with any medical health care professional and is not intended to be in any way a diagnosis or conflict with any other recommendation or treatments by other practitioners who are licensed by state and federal laws, and also the decision to follow or reject this program is left to my own discretion.
- In addition, I fully and completely understand that you do not treat nor do you make recommendations for the treatment of disease in any form or in any manner whatsoever, and I wish to assure you that I am in no way asking for such treatment.

CLIENT SIGNATURE: _____
(e-signatures must be in the format of /name/ using a font other than Arial and Times New Roman)

DATE _____

CONSENT TO TREATMENT OF A MINOR By my signature below, I hereby authorize _____ to conduct a health analysis service to my child or dependent as necessary.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

Name: Birthdate:

Address:

Phone:

Email:

CLIENT INTAKE FORM

HEALTH CONCERNS, ALLERGIES, SURGERIES

	List 1-10 major health concerns, including allergies, surgeries and other important medical info
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

HEALTH GOALS – PHYSICAL, MENTAL & EMOTIONAL

	List your top 3 health goals
1	
2	
3	

DIGESTIVE

"X"	Physical	"X"	Emotional
☐	Hungry all of the time	☐	Not able to "digest" a situation
☐	Gas	☐	Self-esteem, self-worth
☐	Bloating	☐	Confusion
☐	Hard time gaining weight	☐	Feel like you are losing control
☐	Poor appetite	☐	Loss of interest, negativity
☐	Carving carbs and fats	☐	Feeling undernourished or taken care of
☐	Heartburn or acid indigestion	☐	Can't believe someone has "burned" you
☐	Food sits heavy in stomach after eating	☐	Overwhelmed and overburdened

INTESTINAL

"X"	Physical	"X"	Emotional
☐	Diarrhea	☐	Worry
☐	Constipation	☐	Not letting a feeling or situation go
☐	Allergies, hayfever	☐	Irritated by circumstances, feel attacked
☐	Ulcers	☐	Self-doubt, not feel good enough
☐	IBS, Colitis, Crohn's	☐	Bombarded and overwhelmed
☐	Itchy nose, ears	☐	Feel like you are being invaded
☐	Nightmares	☐	Feel like you are being attacked
☐	Hard time losing weight	☐	Depression and withdrawn
☐	Muddled thinking, confusion	☐	Distracted easily
☐	Body odor, bad breath	☐	Negative thoughts; negativity in general

HEPATIC (LIVER & GALL BLADDER)

"X"	Physical	"X"	Emotional
☐	Liver congestion	☐	Anger, aggressive, assertive
☐	High Cholesterol	☐	Over-protecting and controlling
☐	Low Cholesterol	☐	Feel overpowered and defeated
☐	Headaches – tension, migraines	☐	Harboring a heated situation
☐	Hemorrhoids	☐	Fear about meeting personal demand or goal

RESPIRATORY

"X"	Physical	"X"	Emotional
☐	Asthma, shortness of breath, wheezing	☐	Outburst of or uncontrollable grief
☐	Sinus congestion	☐	Feeling stuck or suffocated
☐	Bronchitis, pneumonia	☐	Silent grief
☐	Dry cough	☐	Hurt, hopeless, despair
☐	Wet cough or excess mucus production	☐	Guilt

URINARY

"X"	Physical	"X"	Emotional
☐	Frequent urination (day and/or night)	☐	Annoyed about a circumstance or situation
☐	Skin irritations, blemishes, dry skin	☐	Suppressed hostility, feel threatened
☐	Excess oily skin	☐	Blame others
☐	Excessive perspiration	☐	Feel superior
☐	Limited or no perspiration	☐	Feel inferior
☐	Scant or little urine with urge to go	☐	Feeling worthless
☐	Excessive urine when voiding	☐	Bottling up or holding emotions in
☐	Burning urination, frequent urinary tract infections	☐	Fear; Phobias
☐	Incontinence and bladder leakage, bedwetting	☐	Lack of trust of self and others
☐	Leg cramps, spasms	☐	Fear of the future
☐	Lower back pain, backache	☐	Feel beaten down
☐	Dizziness or light-headedness	☐	Nt feel centered, grounded or peaceful
☐	Puffiness under the eyes	☐	Willingness to do something, lack willpower
☐	Gout	☐	Need to dominate, intolerant to others

LYMPHATIC

"X"	Physical	"X"	Emotional
☐	Swollen lymph glands	☐	Feel stopped in your tracks, emotional paralysis
☐	Edema, water retention	☐	Holding onto a negative emotion
☐	Acne	☐	Not accept self or allow self to receive

CIRCULATION

"X"	Physical	"X"	Emotional
☐	Poor circulation	☐	Feel stuck in life, nowhere to go
☐	Varicose and/or spider veins	☐	Discouraged and disheartened
☐	Wounds heal slowly in extremities	☐	Deep emotional wounding
☐	Pale complexion, anemia	☐	Find excuses not to do something
☐	Always feeling cold (hands, feet, extremities)	☐	Lack of movement in life, not driven
☐	High Blood Pressure	☐	Deep emotional issues
☐	Low Blood Pressure	☐	Lack of love in life, feel unloved
☐	Heart issues; Heart palpitations	☐	Jealous, envious
☐	Absent-minded, forgetful	☐	Feel alienated or lonely
☐	Teeth & Gum Issues	☐	Feel wishy-washy about making decisions

IMMUNE

"X"	Physical	"X"	Emotional
☐	Chronic illness	☐	Unresolved emotions
☐	General weakness	☐	Stuck or entangled emotions
☐	Extreme fatigue	☐	Exhausted from giving to others
☐	Frequent cold sores, viral issues	☐	Something eating away at you, bitterness
☐	Earaches	☐	Not want to hear what people are saying
☐	Sore throat, laryngitis	☐	Not able to express self or speak up for self

NERVOUS

"X"	Physical	"X"	Emotional
☐	Stress affecting quality of life, nervous tension	☐	Hypersensitive
☐	Low energy levels	☐	Boredom, lack of motivation
☐	Fatigue in the afternoon	☐	Over-responsible and dutiful
☐	Waking up frequently at night	☐	Self-blame
☐	Startle easily, jumpy	☐	Suspicious, not feel safe
☐	Insomnia – trouble getting to sleep	☐	Mental chatter
☐	Insomnia – trouble staying asleep	☐	Restless, on edge
☐	Anxiety, nervousness	☐	Impatient
☐	Neuropathy	☐	Hysteria

GLANDULAR

"X"	Physical	"X"	Emotional
☐	Blood sugar issues (diabetes, mood, etc.)	☐	Loss of joy and sweetness in life
☐	Craving for sugar	☐	Abandonment
☐	Adrenal fatigue	☐	Loss of empowerment
☐	Thyroid, underactive	☐	Lack of self-confidence
☐	Thyroid, overactive	☐	Hysteria, paranoia

REPRODUCTIVE

"X"	Physical	"X"	Emotional
☐	Excessive periods	☐	Resentment
☐	Scant or little periods	☐	Oppressed
☐	PMS cramping, bloating, discomfort	☐	PMS mood swings
☐	Menopausal issues, hot flashes, night sweats	☐	Situation burning you up, not feel wanted
☐	Loss of sexual desire	☐	Frigidity; Hard time connecting with others
☐	Hard time being intimate	☐	Not love self
☐	Infertility	☐	Not able to receive, feel worthless
☐	Prostate issues	☐	Feel responsible to take care of others
☐	Impotence (Erectile Dysfunction)	☐	Guilt

STRUCTURAL (BONES, JOINTS, MUSCLES, HAIR, NAILS)

"X"	Physical	"X"	Emotional
☐	Stiff, aching muscles, bones & joints in the front of the body	☐	Not able to move forward
☐	Stiff, aching muscles, bones & joints in the back of the body	☐	Not able to let go of the past
☐	Weak bones, osteopenia, osteoporosis	☐	No support system
☐	Osteoarthritis; Mobility and flexibility issues	☐	Rigid, inflexible, hard-headed, stubborn
☐	Rheumatoid arthritis, fibromyalgia	☐	Feel like a victim, everyone is out to get you
☐	Brittle fingernails	☐	Not thriving or flourishing
☐	Alopecia, losing hair	☐	Obsessive, compulsive
☐	Skin pigmentation, scarring, discoloration	☐	Loss of identify, loss of individualism

LIFESTYLE QUESTIONS

Sample Questionnaires	Yes/No answers
How many ounces of water do you drink a day?	_____ ounces
What/How many alcohol drinks do you drink per day?	_____ ounces
Do you smoke? Cigarettes, marijuana, cigars?	
How frequent do you exercise? What exercises?	
List any prescriptions you are currently taking:	
List any herbs and vitamins you are currently taking:	
What time to you get to bed on average?	
Do you wake up during the night? If so, what time?	

ADDITIONAL COMMENTS

CUSTOM BLEND FORMULATION

BLEND FORMULATION

Blend Title:
Blend Size:
Blend Application: i.e. lotion, bath salt, roll-on, spray

List Essential Oils & Carriers Selected for Blend	List # of Drops	Explanation for Choosing Your Selections

BLEND INSTRUCTIONS

Instructions for Client
How to use daily:
Number of times to use daily:
Length of use:
Anticipated Results:
Number of times to use daily:
Explain your recommendations:

CLIENT OBSERVATIONS & OUTCOMES: MUST REVIEW WITH THEM WEEKLY

Client Weekly Experience (results, experience, improvements, and challenges)	Was Client Compliant?
Week 1:	
Week 2:	
Week 3:	
Week 4:	
Month 2:	
Month 3:	

BLEND REFORMULATION AND/OR ADJUSTMENTS

Reason for additional blend?	
List Essential Oils & Carriers Selected for Blend	**List # of Drops**

FUTURE GOALS AND PLAN FOR THE NEXT 6-12 MONTHS